

# Obama Health Care Reform Proposal From An International Perspective

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## ABSTRACT

*This paper discusses the importance of reforming the health care system in the United States. In doing so, a sample of industrialized countries that have had an established universal health care plan is analyzed. Furthermore, the proposed reform plan by President Obama is discussed. The future prospects of the proposed reform plan by President Obama is explained in the concluding remarks.*

## INTRODUCTION

The global financial crisis of 2008 and the ensuing recession resulted in a significant change in the world economic outlook. Such a shift will be even more pronounced in the United States. The rescue efforts by the US government to prevent a reoccurring economic depression similar to the 1930s will most likely change the shape and the focus of macro and microeconomic policies for decades to come.

Despite its social and economic importance and the critical conditions that the health care industry in the United States has been in for many years, it still remains neglected. The industry is a complex system comprised of many organizations with varied interest and objectives. This industry has been experiencing major problems which are essentially associated with prolonged inflationary pressures and inefficiencies.

Health care reform has been the focus of the presidential campaign since the late 1980s and the campaign in 2008 was no exception. However, as the signs of pending economic downturn appeared, the campaign debate and policy decisions shifted its focus on varied rescue packages for the financial industry. Shortly thereafter, the financial industry rescue was followed by the bailout of the auto industry. Initial estimates show that the cost of a bailout in order to prevent another Great Depression, assuming other industries don't follow the suite, will be trillions of dollars.

The objective of this paper is two-fold. First, to discuss the importance of the need for reform and second, with a comparison to other industrialized countries which have an established universal health care coverage, how the proposed reform plan by Barack Obama addresses the shortcomings of the United States. Towards that goal, the paper provides a brief description of the current status of the health care industry. In the following section, health care systems of select industrialized countries are elaborated. Then, the health care reform proposal by President Barack Obama is analyzed. In the final segment, a summary and conclusion is given.

## CURRENT STATUS OF THE SYSTEM

According to Getzen (2007) more than one-half of the health care expenditure in the United States is financed by the government. The rest is paid for by the private sector, namely, insurance companies, individual payers, and charitable organizations. The majority of government financing of the health care is through Medicare and Medicaid programs. Medicare is financing the health care needs of the aged (65 and older) and entirely funded by the federal government. Medicaid, aimed at the health care needs of low income and children, is a state and federal partnership. Both programs have grown in size and cost substantially more since their inception in 1966. Through these programs, the government negotiates contracts with care providers. Originally, such contracts were on the basis of fee-for-service which led to an uncontrollable escalation of costs. Later, in the early 1980's,

prospective payment system (PPS) under diagnostic related groupings (DRG) formula, became the norm for reimbursing care givers.

The majority of privately financed health care is done through employer-employee based insurance arrangements. Following the managed care (pre-authorization requirements for major treatments) concept, health insurance companies programs generally offer two options of Health Maintenance Organization (HMO) and Preferred Provider Organizations (PPOs). The former sets more restrictions on choice of providers, and thus have lower premium cost while the latter allows out-of-network choices of doctors and hospitals at a higher premium to subscribers. These companies have a financial incentive to keep costs down, which can be at odds with the intentions of doctors and patients. Like the government, insurance companies also adopted a PPS system of reimbursement. Some contracted care givers are paid for their services on a capitation basis where providers (mostly doctors) agree on accepting subscribers on a fixed (pre-determined) compensation regardless of the extent of patients' use of their services.

The US health care industry is plagued with many serious problems that can be summarized as follows:

- Chronic inefficiencies in the hospital industry
- Rapidly growing number of people without health insurance
- Inadequate and underestimated need for long term care
- Excessively costly malpractice insurance
- Uncontrollable system-wide inflationary pressure

Hospitals have limited control of their costs. They are generally squeezed on two fronts. Rising demand and cost of services on one hand and restrictions on reimbursement for their services from private and public insurance entities on the other. To address some of inefficiencies in the hospital industry via controlling the supply, size and scope of their establishments, state and federal governments have been less than effective. Certificate of Need (CON) programs, a supply control measure, and price regulation through PPS and DRG which resulted in major consolidation in the industry, had little impact on cost inflation.

The United States has been the most prosperous nation in the world, but with a growing uninsured population, this reputation is in direct contradiction with such fame that this country has been proud of. In 2007, over 17 percent of Americans did not have health insurance coverage. That number is expected to be even higher in 2008 due to major economic down turn. Uninsured individuals add to the overall cost of healthcare. They tend to forgo common procedures and treatments, and when they receive care on an emergency basis, the treatment costs are substantially higher. Moore (2007) pointed out that 18,000 die because they are uninsured.

Long term care (LTC) may not be an immediate issue in the United States; however, it is a problem that will be difficult to deal with in the near future. LTC entails a broad range of care that encompasses medical and non-medical services. Services are provided in a semi-medical facility, such as nursing homes, where professional staffs (doctors and nurses) are present. Alternatively, care is give at an individual's home or in some type of assisted living arrangement where nurses go to provide care when needed.

LTC can be expensive, especially since "About 10 percent of the people who enter a nursing home will stay there five years or more" (Medicare, 2008). In 2007, the average annual cost was about \$66,795 (Houser, 2007) but only about 25% of that was paid out-of-pocket. Medicaid and Medicare, along with private insurance, paid for the rest. The need for long term care is only expected to grow as baby boomers near retirement age. The care the elderly receive in their last few years of life can be very expensive depending on the region (Hartocollis, 2008). According to Hogan et al. (2001), the cost of medical care in the last year of life accounts for 27.4 percent of all Medicare outlays. The Census Bureau's statistics predict anywhere between 14 to 54 million American aged over 85 years old by 2040, depending on different mortality and life expectancy rates, (Gavrilov and Heuveline, 2003). Currently, there are about 5 million in that age category. With that projection, the cost of LTC will be exponentially higher.

Another contributing factor to the ongoing crisis in the health care sector has been the vicious cycle of rising malpractice costs, premiums, and its ramifications for the overall health care service costs, accessibility, and availability. In a comparative analysis of the United States and Canada, Mirmirani and Lippmann (2003) noted American doctors experience ten times more legal actions against their practices than their Canadian counterparts. Not surprisingly, such a wide disparity has been reflected in their malpractice premium costs which led physicians in the U.S. with higher-risk practices, e.g. OBGYNs and surgeons, to leave or switch their practices that they have been trained for. This situation has created shortages of physicians, in some states which have experienced higher rates of legal actions. The rate of growth of malpractice awards in the United States has been significant. For example, the median award in 1995 was \$500,000 and in 2000 such median rose to \$1,000,000 (Jury Verdict Research-Horsham, PA., 2003).

Healthcare costs have risen uncontrollably over the last four decades. The growth is expected to continue as the American population ages and Baby Boomers gear up for retirement. Past government efforts to control costs have proven to be ineffective. With the exception of the late 1970s, health care cost inflation persistently exceeded those of the national rate.

Most would argue that the improvements in health care are worth paying for since it is hard to put a price on health and well-being. Any changes to the current healthcare system must weigh the benefits of quality with the cost of the care. While it would be beneficial to add more technology, preventative care measures, and research and development, it should be understood that these investments, if deemed appropriate and deliver what they promise, tend to have a long-term pay-off. Since scientists and researchers are not the end users of the research and development they produce, this can lead to overproduction of research (in a costs-benefits scenario).

Most people see healthcare costs through their health insurance coverage (and/or non-coverage); and for this reason, policy makers tend to see health insurance as a way of lowering healthcare costs. There are other ways to lower the cost of health insurance such as reducing the number of preventable errors, and the number of uninsured people. The uninsured add to the cost of healthcare because they often forgo basic procedures and treatments. As a result, their problems accumulate and become more complex, and then treatment is sought on an emergency basis which usually costs substantially more than preventative cares. In the case of an emergency, care cannot be denied, but must be absorbed by the hospital or insurance companies, whether the person is covered under a policy or not. “[The uninsured] pray every day that they don’t get sick because 18,000 will die this year simply because they are uninsured,” (Moore, 2007). Reducing the number of the uninsured is regarded as the first step to lowering the overall cost of the healthcare system.

## **INTERNATIONAL COMPARISON**

In an international context, a quick highlight of the current status of the health care system in the United States reveals the following:

- Highest per-capita expenditure in the world
- Highest % of GDP share in the world
- 5th lowest acute hospital bed per-thousand population among OECD nations
- 8th lowest number of MDs per-ten thousand population among OECD nations
- 2nd largest number of MRI per-million population among OECD nations

Spending for health care in the US, both in total and as a percent of GDP has exceeded those of any developed country. The health outcomes as measured by life expectancy and infant mortality, the most commonly accepted measure of health output, lagged behind for many years. The positive aspects of such a discrepancy however, have been shorter waiting time for care and the US maintaining its status of being the world leader in healthcare research and development.

The United States is the only OECD nation without universal healthcare. The U.S. spends the most on healthcare, as a percent of GDP, however ranks only 20<sup>th</sup> out of the 30 developed countries for life expectancy, and 25<sup>th</sup> on infant mortality. One should note the gap in outcome can be partially explained by the fact that the

population of the U.S. is much more diverse than other OECD countries which tend to have one major ethnic group with small minorities. Thus, biological and cultural factors may play a part into a lower outcome of key health measures. In a study of the healthcare systems of 22 European countries, Mackenbach et.al (2008) concluded that socioeconomic factors such as alcohol consumption, obesity, and smoking are factors in the inequalities in health.

It is important that the universal health care systems of other countries are analyzed as a guide for restructuring the US health care system. Of particular interest in our focus are those of the United Kingdom, Japan, Canada, France and Germany. The focuses on the universal health care systems in these countries are access, quality, financing, and outcomes. The selection of these countries is motivated by varied reasons. The United Kingdom for its long history with the universal health plan and the two tiered system of coverage, Japan for its highest health outcomes (life expectancy and infant mortality) and quality of care, Canada for its proximity and prior role in drafting health reform plans in the US in 1990s, France and Germany for their system of maintaining quality of care at a controlled cost and having the most satisfied population. The French health care system was rated the best by the World Health organization (WHO) in 2001. Among the various features of the French system are universal coverage, responsiveness of providers, and patient and provider freedom as noted by the WHO. The United States was ranked number 37.

**Table 1 - Comparative Characteristics of Healthcare Systems**

	<b>UK</b>	<b>Japan</b>	<b>Canada</b>	<b>France</b>	<b>Germany</b>	<b>US</b>
Principle of Right to Health Care	Yes	Yes	Yes	Yes	Yes	No
Insurance Connected to Employment	No	Yes	No	Yes	Yes	Yes
Private Insurance Allowed	Yes	Yes	Yes	Yes	Yes	Yes
Gate Keepers to Specialists	Yes	No	Yes	No	No	No
Government Main Source of Financing	Yes	No	Yes	Yes	Yes	No
Long Waiting Time for Primary Care Doctors	No	No	Yes	No	No	No
Portable Insurance	Yes	Yes	Yes	Yes	Yes	No
Prescription Drugs Coverage	Yes	Yes	No	Yes	No	Yes

**Table 2 - Comparative Healthcare Expenditures, Resources and Outcomes**

	<b>UK</b>	<b>Japan</b>	<b>Canada</b>	<b>France</b>	<b>Germany</b>	<b>US</b>
% of GDP	8.3	8	9.8	11.1	10.7	15.3
(\$) Per Capita	2,724	2,358	3,326	3,374	3,287	6,401
Acute Care Beds Per 1,000 Population	3.1	8.2	2.9	3.7	6.4	2.7
MRI Scanner Per Million Population	5.4	40.1	5.5	4.7	7.1	26.6
Life Expectancy at Birth (combined male and female)	79	82	80.2	80.3	79	77.8
Infant Mortality Rate Per 1,000 Births	5.1	2.8	5.3	3.6	3.9	6.8

Source: OECD Health Data 2007, OECD, Paris, July 2007

Table 1 reveals that as opposed to the United States, the selected countries all offer universal health care on the basis of the principle of right to care and not affordability to pay for their respective citizens. They all share a system where insurance is portable, and except for Canada all don't have problems with long wait for services. Other characteristics vary by country.

Table 2 shows the United States spends significantly more on healthcare (in total and as % of GDP), has the lowest hospital bed population ratio, second highest (next to Japan) MRI scanners, the lowest life expectancy and the highest infant mortality rate. A brief overview of each of the countries mentioned above is provided below.

**British System (NHS)**

In the United Kingdom health care services and universal health coverage is guaranteed under the National Health Service (NHS). In this system, coverage is not linked to the employment status of citizens (DiPiero, 2004). Therefore, portability of health care coverage is not an issue. All citizens have access to a general practitioner and

the majority of physicians are employed by the NHS. However, they are permitted, at a separate fee, to see patients not part of NHS (Hohman, 2006). According to Gaydos and Fried (2002), general practitioners “serve as gate keepers to specialist care.” Specialists are allowed to work outside the NHS but only on a part time basis (DiPiero, 2004). The hospitals in the United Kingdom are usually self-governing, independent entities (Gaydos & Fried, 2002).

The quality of the National Health Service is mixed. There are short wait times to see general practitioners (Hohman, 2006) and even longer wait times are an issue for specialists’ care (Light, 2002). However, appointments with general practitioners are plagued by impersonal relationships and dismal communication (Coulter and Magee, 2003). If a faster service or an elective procedure is desired, then a private insurance is the channel to receive such care. However, the quality of those services may not be better than or in some cases, can be worse than those offered under the NHS coverage (Light, 2002). Large bureaucracy is a drain on resources. There is also a lack of a uniform quality indicator or enforcement. Finally, the NHS establishes limits on medical treatments which decrease one’s chance of surviving certain illnesses. This rationing of care has led to the cost per person of \$3,800, which is about half of the cost in the United States (Silberner, 2008).

The government provides the overwhelming majority of financing for the NHS. The primary source of funds is the national income tax. Individuals do have to pay for eye services, long term care, and dental care (Gaydos & Fried, 2002). There is a copayment arrangement for prescription drugs, although eighty-five percent are exempt from co-payments. According to Dixon and Robinson (2002), hospital physicians are government employees, and thus paid by the government. Other practicing doctors are reimbursed on a capitation basis.

The health care system in United Kingdom can be a guide for the United States for the following reasons. First, it provides a two tier model that could be of use to the United States in which one tier represents primary care for all citizens while the other tier represents private insurance which can be bought to receive additional and delay-free services. The NHS structure which forces consumers to be more responsible, can be a useful model for the United States, one in which health care not be deemed as free care because of its co-payment requirements (Light, 2002). Furthermore, the NHS can be a good guide for its emphasis on preventative care, in which general practitioners have financial incentives when they meet certain population-based prevention targets (Light, 2002).

### **Japan’s System (NHI)**

All citizens in Japan enjoy mandated health insurance coverage via National Health Insurance (NHI). This system encompasses coverage for employees, self employed or unemployed, and the elderly. There is no “gate keeping” or restricting access to medical services. In comparison, on average, Japanese patients visit doctors three times more than those in the United States.

The quality of the country’s health care is fairly high - waiting for service is short if non-existent, accessing specialists is fairly easy - all of which lead to relatively better health outcomes. The higher level of technology in the system is evidenced by the fact that the MRI scanners per capita in Japan is twice those in the United States. Hospitals compete on quality and technology since price competition is banned (Hohman, 2006).

The method of payment for the health care depends on the economic status of individuals. Those who are employed pay premiums under the Employee Health Insurance and the level of premium (shared between employee and employer) are linked to their income. There is also co-payment (with a cap on total payment) arrangement for the cost of services rendered by physicians and hospitals. Those enrolled in the National Health Insurance plan have similar responsibilities and cost sharing arrangements. General financing of the health care is regulated by the government that sets the price for all medical procedures.

One main aspect of the Japanese universal health care system which could benefit the United States is the practice of competing on quality, not price, by hospitals. Also limiting the maximum cost of payment for services for individuals is another advantage of the system in Japan that promotes equity.

**Canada's System (Medicare)**

Canada's system of universal health care coverage, also known as "Medicare" is based on the core principle of "comprehensive coverage for medically necessary hospital and physician services" (Health Canada, 2005). Currently, this system is perhaps the most socialized health care delivery method among industrialized countries. The overall guidelines are being set at a federal level and administration is being done at the provincial level. Similar to the United Kingdom's health care system, health insurance in Canada is not tied to employment. Canada's health insurance is comprehensive, portable, accessible, and life long. The Canadian system only allows private insurance for procedures that are not covered by providential insurance (DiPiero, 2004). Finally, Canadians are allowed to choose their own primary care physician (Health Canada, 2005).

The quality of Canada's health care has been questionable due to long wait times for treatments. This has reached a level of national debate and legal challenge at high court levels. In the Court's ruling, it stated that "waiting lists for health care services have resulted in deaths, have increased the length of time that patients have to be in pain and have impaired patients ability to enjoy any real quality of life" (Steinbrook, 2006). According to Deber (2003), the quality of the Canadian health care system is further reduced by gaps in public coverage. Other problems in the system include physician shortages and lack of innovation in pharmaceuticals.

The government provides the majority (over 70%) of financing for care under Canada's universal health care system. The government secures funds through federal, provincial, and territorial taxes. Citizens pay for prescription drugs, dental care, vision care, and medical equipment either out-of-pocket or through private insurance. In general, physicians, particularly those in private practice, are reimbursed through a fee-for-service basis as negotiated by the provincial and medical associations. Hospitals are reimbursed based on yearly global (provincial) budgets (Health Canada, 2005).

Perhaps, the one area in the Canadian universal health care system that can assist reform in the United States is the oversight and budgetary arrangement. In this case, the Federal government has a supervisory role and there are provisions for independency among states to manage financing of the health care needs of their respective residents.

**France's System (NHI)**

The French system of universal health (NHI) coverage is best known as public-private partnership. In this partnership, hospital and ambulatory services are deemed the highest ranking by the World Health Organization (WHO) in 2000. The majority of ambulatory care is based on solo practice and fee-for-service arrangement. French citizens are enrolled in an insurance program in which premiums are based on occupational status. Beyond the basic coverage, French citizens, about 90%, subscribe to some form of supplementary insurance that covers services not included in the NHI. Core principles that guide NHI are liberalism and pluralism (Rodwin, 2003). These principles assure coverage for all and freedom of choice - patients may choose their own doctors and specialists with no gate keeping restriction and physicians can enjoy clinical freedom. Rodwin (2003) characterizes the organization of the French system as "bilateral monopoly" where NHI is the single buyer of medical services, a monopsonist, and physician associations are the monopoly supplier.

French workers pay about 21 percent of their earnings into NHI. An employer's contribution is about one-half of that amount. The main source of financing the system comes from social security contributions (13.55 percent payroll tax of which an employee's share is less than 1% and 5.25% general social contribution tax on income). The compensation method for physicians is similar to those in the United States - contracted arrangement (PPS method) following DRG formula. The government's attempt to control cost has been focused on encouraging responsible consumer demands and establishing moderate co-payment for services. More recently, due to a rising deficit in the NHI budget, the government is taking steps rising the level of co-payments for prescription drugs, ambulance, and other services.

### **Germany's System (Sickness Funds)**

German universal health coverage - a mandated coverage - provides insurance through "sickness funds." Sickness Funds are independent, non-profit, and based on occupation (DiPiero, 2004). Sickness Funds are essentially employer and employee entities regulated by the government. Germans have their choice of which sickness fund they wish to join. Premiums are set as a percentage of one's salary promoting equity in the system (Knox, 2008). The self-employed and those in high-income brackets may opt for private insurance coverage. Retirees are covered by sickness and retirement funds.

Germans enjoy relatively easy access to primary medical services and short waiting times for elective surgery. Germany's health insurance guarantees coverage regardless of pre-existing health conditions. Children are covered under their parent's insurance and have extended benefits of no pay co-payments and free prescription drugs (Knox, 2008).

In general, Germans pay 8 percent of their gross income and their employers pay about the same (Knox, 2008). In addition, the government helps fund deficits in health care for the elderly. Out-of-pocket costs of patients are capped at two percent of their income. Reimbursement of physicians, as set by sickness funds and is on a fee-for-service basis. Hospitals and hospital-based doctors who are salaried employees are funded by sickness funds (DiPiero, 2004).

The main aspects of the German health care system, which can help the United States to formulate its reform, are an emphasis on employee-employer arrangement and equity considerations. Another important feature is the focus on extended and more liberal coverage for children.

Looking at the various features of the health care systems explained above, with the goal of universal health care coverage for all Americans, we can summarize those that could serve as a foundation in drafting a plan for the United States. Those important aspects are:

- A system with built-in incentives for preventive care
- A system with built-in incentives for competing on quality and not price
- A partnership between public and private insurance entities
- A system of choice for patients and providers
- A controlled environment for medical malpractice litigations
- Income-based premium payments with co-payment provisions
- Guaranteed coverage for all citizens, with special provisions for children
- Prescription drug cost supervision

### **REFORM INITIATIVES**

The debate on reforming the United States health care system is not new. Making a significant change in the system was inspired by Senator Edward Kennedy of Massachusetts decades ago; however, the momentum was picked up by President Clinton's aspiration for establishing a universal health care system in early 1990s. Because of the political climate during the time where both Houses of Congress were dominated by republicans, Clinton's health care reform proposal did not go beyond congressional debate (Blumenthal, 1995). In the meantime, industry problems and issues continued the path of crisis and failure.

As recent as 2008, political campaigns concentrated on health care issues in the United States once again. Currently the reform proposal by President Obama seems to be the focus of policy makers; therefore, it is important to know in more details how the future of health care will take shape if implemented.

### **Obama's Health Care Reform Proposal**

To ensure coverage for all, the Obama plan mandates insurance companies to take in subscribers regardless of their pre-existing conditions, creates a national exchange in which people and small businesses can pool together to buy insurance, and requires large companies to contribute to healthcare. The proposal has particular interest in:

- Quality Improvement
- Lower Costs
- Improved Access
- Affordable Healthcare

To achieve the above, a number of strategies are set. Below summarizes those strategies:

- Invest about \$10 billion per year for next 5 years in Electronic Health Information Technology Systems
- Improve access with focus on prevention & disease management programs
- Require transparency regarding costs and quality
- Coordinate and integrate care to promote efficiency, quality and patient safety
- Create incentives for excellence
- Tackle disparities in health care among population
- Reform medical malpractice while preserving patient rights
- Support disease management programs

The goal of lowering the cost of medical care is an important component of the plan. This is done by:

- Increasing competition in the insurance industry
- Preventing private insurance waste and abuse of Medicare
- Allowing consumers to import safe drugs from other countries
- Preventing drug companies from blocking generic drugs from consumers
- Allowing Medicare to negotiate for cheaper drug prices
- Reducing costs of catastrophic illnesses for employers and their employees

In order to make health care affordable and accessible for all, the proposed reform plan offers the following:

- Guaranteed eligibility
- New, affordable and accessible health insurance options
- Affordable premiums, co-pays and deductibles
- Portability and choice
- Employer contribution
- Required coverage for children and expansion of Medicaid and SCHIP

On promoting prevention and strengthening public health, Obama's plan tends to focus on many social factors. Among them are:

- Overall need to confront smoking, obesity, and food and water safety
- Encourage employers to offer onsite flu vaccinations, nutritious foods, and exercise facilities
- School system support for health screenings, financial support for phys. ed., and obesity prevention programs
- Workforce infrastructure support to improve working conditions and grants for training curricula
- Restrict advertising of tobacco and alcohol to children, expanding community based preventive interventions
- Federal, state, and local governments collaborate on national and regional strategy for health care



Experts and policy analysts are in support of the need for restructuring and the plans that President Obama's proposal is promising. It includes an incentive mechanism for lowering cost while maintaining quality, and addresses the compounding problem of the uninsured. As an example, Cutler et al. (2008) suggests the plan would curtail excessive power by health insurance pharmaceutical industries, modernize our current system of employer- and government-provided health care, keeping what works well, thus leading to a more responsive and efficient system. The important question is how well such restructuring will be implemented in the future. The answer will depend on how businesses react to the pay-or-play system, and how the insurance industry responds with their powerful lobbying in Congress.

## **FUTURE PROSPECTS**

Considering recent responses by the public and the insurance industry, the likelihood of establishing some form of compulsory insurance is good. The insurance industry which rejected Clinton's universal health insurance plan in 1992 is now supporting an overhaul in the health care industry (Pear, 2008). This tends to increase the chance of Obama's health care reform plan to pass. It is also possible health care coverage for all will be in the form of a tiered system in which those who can afford to pay more will benefit from extended coverage beyond the basic plan covering all others.

There are some serious obstacles in implementing Obama's plan for overhauling the health care system in the United States. A dismal fiscal outlook and resistance by the health care constituencies who might be adversely affected by such changes (Goldsmith, 2008). The recession started in 2008 and projected to continue in 2009 and perhaps even the early part of 2010 has already dramatically increased the national debt. Early projections for Federal deficit, not including stimulative packages, is estimated to be approximately one trillion dollars, thus dampening the efforts of restructuring the health care delivery in the United States. Also, mandating employers, unless they are ensured potential growth in business, to offer health insurance to their employees has the potential to derail Obama's plan.

If major change in the health care sector does not occur during Obama's presidency, it will be a missed opportunity and this important social and economic factor of American life will continue the path of demise.

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